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ABSTRACT

This booklet provides mental health professionals with an analytic framework for understanding psychosocial reactions to bereavement of adults and children and for selecting appropriate intervention strategies. It also identifies those people most likely to need the intervention of a mental health professional to help prevent or mitigate pathologic grief responses, and the symptoms that indicate a need for professional help. It begins with a section addressing the issue of whether or not grief is a disease. A section on adult reactions to bereavement looks at the phases of bereavement reactions and the end of the bereavement process. It identifies those who may be at risk following bereavement and points out some indications of a need for professional intervention. A section on bereavement and children examines children's fears, fantasies, and behavior and identifies children at risk for poor outcomes. A section on models of the bereavement process considers social support and sociocultural influences and offers cautions about the use of medications. Other sections discuss supportive interventions, community resources, and the impact of bereavement interventions. References are included; support group information is appended. (NB)

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mental health professionals and the bereaved

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INTRODUCTION

Every year an estimated 8 million Americans suffer the death of an immediate family member, and an unknown number experience the death of other important relatives and close friends. Every year, there are 800,000 new widows and widowers. Suicide occurs in at least 27,000 families each year (and probably many more since suicide is underreported). Each year, approximately 400,000 children under the age of 25 die. Only those who die young escape the pain of losing someone they love through death. Just as each type of relationship has special meaning, so too does each type of death carry with it a special kind of pain for those who are left behind.

Bereavement is usually considered to have the most powerful impact of all stressful life events. In addition to feelings of grief and emotional distress, perturbations in physiologic functioning and interpersonal relations are very common. To be bereaved has been likened to being an immigrant in a foreign country—social relationships are altered, expectations for behavior are unclear, and one is generally disoriented. The established rhythms of everyday life are likely to be upset.

As with many other stressors, the consequences of bereavement are not uniform; many factors can modify that stress and affect long-term outcomes. The sudden and unexpected suicide of a young husband and father, for example, is likely to have much more profound effects on surviving family members

than the long anticipated death of a beloved and elderly grandparent.

Although clearly not unique, some aspects of loss through death are distinctive. Even superb coping abilities cannot alter the finality of death. The survivors' helplessness and total inability to control the event may make bereavement particularly stressful. Understanding the nature of the bereavement process and why it is so long and difficult may help those who are experiencing it to cope, and help those who wish to assist the bereaved be more effective.

This booklet is designed to provide mental health professionals with an analytic framework for understanding psychosocial reactions to bereavement of adults and children and for selecting appropriate intervention strategies. It also identifies those people most likely to need the intervention of a mental health professional to help prevent or mitigate pathologic grief responses, and the symptoms that indicate a need for professional help. With knowledge of the factors that predispose some people to increased risk of adverse outcomes, the possibility of early preventive intervention may be enhanced, particularly because some of these factors can be identified before or very soon after bereavement.

IS GRIEF A DISEASE?

The typical early manifestations of grief—crying and sorrow, anxiety and agitation, sleeplessness, lack of interest in things, and loss of appetite—are similar in nature and intensity to the manifestations of clinical depression.

Whether grieving individuals with these depression-like symptoms are ill has been the subject of some controversy. In his classic paper, *Mourning and Melancholia*, Freud (1917) distinguishes between grief and depression. Grieving people feel a loss or emptiness in the world around them, while depressed patients feel empty within. The current consensus is that although individuals experiencing grief are distressed, they are not sick.

As is true of some mental disorders, the line between "normal" and "abnormal" bereavement reactions can be difficult to draw. The American Psychiatric Association's *Diagnostic and Statistical Manual – III* includes a category called "Uncomplicated Bereavement" that offers some guidance:

> A full depressive syndrome frequently is a normal reaction to such a loss, with feelings of depression and such associated symptoms as poor appetite, weight loss, and insomnia. However, morbid preoccupation with worthlessness, prolonged and marked functional impairment, and marked psychomotor retardation are uncommon and suggest that the

bereavement is complicated by the development of a Major Depression.

In Uncomplicated Bereavement, guilt, if present, is chiefly about things done or not done at the time of the death by the survivor; thoughts of death are usually limited to the individual's thinking that he or she would be better off dead or that he or she should have died with the person who died. The individual with Uncomplicated Bereavement generally regards the feeling of depressed mood as "normal," although he or she may seek professional help for relief of such associated symptoms as insomnia and anorexia.

The reaction to the loss may not be immediate, but rarely occurs after the first two or three months. The duration of "normal" bereavement varies considerably among different subcultural groups.

Mental health professionals must judge whether an individual's grief has exceeded the bounds of normalcy to the point where it is pathologic and intervention is needed. Until the patterns of normal bereavement are understood, however, it is not possible to develop sound criteria for abnormal reactions. The sections that follow describe the range of reactions that have been observed in bereaved people by clinicians and researchers.

ADULT REACTIONS TO BEREAVEMENT

Everyone assumes that sadness accompanies the death of a loved one, but the bereavement experience contains a much broader range of emotional reactions and behaviors. Some may not only be surprising, but can be upsetting if they seem inappropriate to those who do not understand them. Knowledge about the various processes and outcomes associated with bereavement is likely to help avert some of the misunderstanding that can make the experience more difficult.

The first systematic study of bereavement was conducted by Erich Lindemann in 1944. He described uncomplicated grief as a syndrome with a predictable course and distinctive symptoms, including (1) somatic distress, (2) preoccupation with the image of the deceased, (3) guilt, (4) hostility, (5) loss of usual patterns of conduct, and, in some people (6) appearance of traits of the deceased (such as mannerisms or symptoms associated with the final illness) (Lindemann 1944). Since that time, numerous clinicians and researchers have sought to corroborate these observations and to describe the grieving process in adults.

It is now generally agreed that:

> ***The bereavement process is long***, much longer than popular American notions would lead us to believe. Although, for many people, the worst is over within a year, evidence suggests that for some people the second year is more

difficult than the first. For many people, the process may take several years.

The bereavement process does not necessarily progress in an orderly fashion, that is, people do not move systematically from one well-defined stage to another. Instead, they tend to move back and forth between what might be best described as overlapping and fluid phases.

Individual variation is substantial. People differ in how fast they recover and how they express their grief. Specific manifestations of grief depend on the personality and past experiences of the bereft person, cultural norms and expectations for behavior, the relationship with the deceased, the nature of the death, and the social milieu of the bereaved person.

Many emotions and behaviors that might be judged abnormal under other circumstances are common following bereavement. Nevertheless, some signs and symptoms may indicate serious problems that deserve the attention of a qualified mental health professional. However, the line between normal and abnormal (or pathological) is difficult to draw.

Anniversary reactions are common, even after the bereavement process is completed in the sense that one is again able to function and take pleasure in life. It is typical to experience new waves of grief around holidays, important family events, and the time

of year when the death occurred. These anniversary reactions may become briefer as time goes by, but they may never entirely disappear.

The Phases of Bereavement Reactions

There is general agreement that forewarning of death permits the soon-to-be-bereaved to structure the event cognitively and to reconcile differences with the dying person in a way that can reduce some of the anger and guilt commonly felt after bereavement. There is disagreement, however, about whether anticipatory grieving allows people to begin to relinquish the relationship or whether attachment intensifies when a person is threatened with a loss (see, for example, Bowlby 1980; Parkes and Weiss 1983).

The most immediate response following death, even when the loss was anticipated, is shock, numbness, and a sense of disbelief. Because the reality of the death has not yet penetrated awareness, survivors can appear to others to be holding up well and to be quite accepting of the loss. This numbness usually turns to intense feelings of separation and pain in the days and weeks after the funeral. Beverly Raphael, a well-known Australian psychiatrist, describes this phase in the following way:

> The absence of the dead person is everywhere palpable. The home and familiar environs seem full of painful reminders. Grief breaks over the bereaved in waves of distress. There is intense yearning, pining, and longing for the one who has died. The bereaved feels empty inside, as though torn apart or as if

the dead person had been torn out of his body (Raphael 1983).

During this phase, the bereaved frequently report illusions and misperceptions, such as seeing the dead person in the street and dreams in which the deceased is still alive. Eventually, these searching behaviors begin to decrease, but when the lost person fails to return, despair sets in. Symptoms such as depressed moods, difficulty in concentrating, anger at the deceased for dying and at the doctors who cared for him or her, guilt about what else might have been done to avoid death, irritability, anxiety, restlessness, and extreme sadness then become common. Offers of comfort and support are often rejected because the grieving person is so focused on the deceased.

The bereaved may swing dramatically and swiftly from one feeling state to another, and avoidance of reminders of the deceased may alternate with deliberate cultivation of memories for some period of time. Gradually the death begins to be accepted. However, the bereaved may be intellectually aware of the finality of the loss long before they emotionally accept the truth. Depression and emotional swings are characteristic of most people for at least several months and often for more than a year following bereavement. Eventually, the survivor is able to recall memories of the deceased without being overwhelmed by sadness or other emotions, and is ready to reinvest in the world.

Accompanying these emotional changes are changes in physiologic functioning, behavior, and social relationships. The functioning of major bodily systems is likely to be altered during times of stress, including grief. Changes in the endocrine, immune, autonomic nervous system, and cardio-

vascular system have been documented by many researchers, but the health consequences of these changes are not yet established.

Physiologic perturbations clearly represent reactions to a stressor—in this case, bereavement. However, just as psychosocial reactions may or may not presage mental disorder, physiologic reactions may or may not lead to documentable health consequences. They are probably adaptive physiologic responses that may become maladaptive and eventually deleterious to health if they continue for too long or become too extreme. That a normal physiologic adaptation to grief can become unregulated and lead to illness is consistent with modern views of the pathogenesis of some autoimmune diseases.

A number of case studies appear to link grief and specific diseases such as various forms of cancer, heart disease, and ulcers (see, for example, Schmale and Iker 1965; Greene 1965). Establishing causal connections is difficult because of statistical problems and the low base rate. It also seems more reasonable to consider bereavement a nonspecific stressor that triggers multiple changes which, in people who are vulnerable because of genetic predisposition, or past or current illness, might lead to disease.

Quite apart from actual disease, recently bereaved people frequently report a host of physical complaints. These include pain, gastrointestinal disturbances, sleep and appetite disturbances, lack of energy, and other vegetative symptoms that at another time might signal the presence of depression. Especially in the elderly, these grief-related symptoms may be misdiagnosed as organic dysfunction if health professionals are not aware of the nature of bereavement reactions and the history of the particular patient.

Behavioral changes accompany these physical complaints and emotional upset. Just as emotions may swing, so too may the bereaved person appear slowed down at one moment and restless and agitated the next. Crying and tearfulness are common. When emotional despair sets in, the bereaved may lose interest in the outside world and cease their normal activities including such relaxing pastimes as watching television or listening to music.

Certain risk-taking behaviors may intensify or appear for the first time. Smoking, drinking, and drug taking are common, especially among people who were already engaged in those behaviors to some extent before the bereavement. Altered eating habits (over- and under-eating and changes in the kinds of foods consumed) are also common expressions of depression that can be harmful, particularly for diabetics and others whose diets need to be carefully controlled. Behaviors such as these are an indirect expression of emotional distress that may eventually compromise a person's health.

Finally, bereavement often precipitates changes in interpersonal relationships in the family and in one's broader social network. Family roles and patterns of interaction are likely to shift after the death of a member. Bereft parents, for example, may be less emotionally available to their children because of their own grief, thus compounding the children's sense of loss.

Outside the family, the bereaved not only see themselves differently in relation to others, but are likely to be perceived in a new way. For example, suddenly, thinking of another as a "widow" may evoke particular stereotypes or expectations, resulting in different qualities being arbitrarily ascribed to the person. The nature of these interpersonal changes is largely dependent on the rela-

tionship that was lost and sometimes on the nature of the death.

These changes are also powerfully influenced by the sociocultural context in which the person lives and by the bereaved person's age. For example, a middle-aged widow or widower may find social life greatly curtailed because people tend to socialize in couples. Elderly people may find that most of their friends and relatives have died, leaving few familiar people to be with. Especially when one is elderly and upset, making new friends can be difficult. Thus, social isolation and feeling of loneliness are common, often long after the bereavement.

The End of the Bereavement Process

When does the bereavement process end? What are the signs of a favorable outcome? There are no clearcut answers to these questions. Terms such as "recovery," "adaptation," and "completion" have been used to describe the end of the bereavement process. Each term has a somewhat different connotation and contributes to understanding, but no single term provides an adequate description.

A healthy bereavement process can be expected to end with recovery of lost functions (including taking an interest in current life, hopefulness, and the capacity to experience gratification), adaptation to new roles and statuses, and completion of acute grieving. Both favorable and unfavorable outcomes along several dimensions can be identified.

One of the most important dimensions is time. Despite the popular belief that the bereavement process is normally completed in a year or less, data from systematic studies and from clinical reports confirm that the process may be considerably more attenuated for many people and still be considered

normal. The length of time per se does not distinguish normal from abnormal grief, but the quality and a quantity of reactions over time. Thus, a precise endpoint cannot be specified.

Just as individuals vary in their reactions to bereavement, so, too, do they vary in outcomes. What may signal a healthy recovery for one individual may be a sign of continuing difficulty for another. For example, readiness to invest in new relationships does not invariably indicate completion of or recovery from bereavement. A seemingly quick remarriage or a decision to have another child after one has died may reflect a sense of hope or strength in one case, whereas in another such actions may stem mainly from a wish to escape from painful emotions.

For some, bereavement provides an opportunity for personal growth that might not otherwise have occurred. Widows who had very traditional marriages, for example, may be forced to take on new roles and acquire new skills following the death of a husband. Being able to rise to these challenges successfully may leave a widow with a greater sense of competence and independence than when she was married (Silverman 1982). Some have observed that bereavement can lead to heightened creativity, noting that numerous successful artists, writers, and musicians have experienced painful losses.

Among the unfavorable outcomes of the bereavement process, it has commonly been noted that 10–20 percent of the bereaved continue to exhibit depressive symptoms after 1 year (see, for example, Bornstein et al. 1973; Clayton and Darvish 1979). Some people appear to be particularly vulnerable to poor outcomes in terms of their mental or physical health.

Those Who May be at Risk Following Bereavement

Because of their particular life situations or personal characteristics, some people have been found to be more vulnerable than others following the death of someone close. In general, children are more vulnerable than adults. The gender and age of bereaved individuals, the nature of the relationship with the deceased, the nature of the death, and certain behaviors and social situations that appear soon after the death may affect how well the bereaved person ultimately fares.

In the months and years following the death of a spouse, widowers are more likely to die than men the same age who have not lost their wives. This increased risk for premature death, which is characteristic for men up to age 75, seems to persist for at least 6 years unless the men remarry. Among widowers who remarry, their likelihood of dying prematurely is no greater than for non-widowed married men of the same age. It is not clear, however, whether marriage itself protects against ill health or whether good health is a factor that permits remarriage.

Increased risk of premature death in the first year after their husbands' deaths does not seem to characterize widows, although there is evidence for higher death rates in the second year following bereavement. Widows are much less likely than widowers to remarry because fewer single men are available (Helsing et al. 1981, 1982; Clayton 1982). This may heighten widows' vulnerability to some other stresses, including social isolation and financial problems, that may require major alterations in lifestyle.

Although hypotheses abound concerning the

relationship between bereavement and the subsequent development of particular diseases, the evidence for these relationships is generally weak. What does seem clear, however, is that people who were physically or mentally sick before bereavement are likely to be more sick afterward. The stress of bereavement appears both to exacerbate preexisting physical and mental disorders and to precipitate or exacerbate certain dangerous behaviors. For example, among widowers, there is an increase in the relative risk of death from suicide, accidents, cardiovascular disease, and some infectious diseases. Widows show an increase in the relative risk of death from cirrhosis and suicide. Thus, among the widowed, both the mortality rates and causes of death differ from the nonwidowed population.

Not only does each type of relationship (spouse, child, parent, sibling) have a different meaning during life and hence a different impact after death, but the nature of the particular relationship may also influence the course of bereavement reactions. The literature on conjugal bereavement is replete with data indicating that individuals who had highly ambivalent relationships with their spouses fare worse following bereavement than people whose relationships were less conflicted (Parkes and Weiss 1983). It appears that ambivalence—the simultaneous presence of positive and negative feelings—heightens the common feelings of guilt following the death of a close person and complicates the emotional grieving process. Also, excessively dependent people—for example, spouses who cannot (or fear they cannot) function independently—do poorly during bereavement (Parkes and Weiss 1983; Lopata 1973).

A sense of guilt may also play a significant role

in creating vulnerability to a difficult and prolonged bereavement process. Children's deaths are generally considered difficult in part because they are likely to create heightened guilt and a sense of helplessness in parents who feel (however irrationally) they should have been able to protect their offspring. For example, the inexplicable nature of the Sudden Infant Death Syndrome (SIDS) can cause parents to assume a burden of guilt. These deaths may be particularly difficult for survivors because of the unexpectedness of the death of an apparently healthy infant. Children's deaths are also out of harmony with our life cycle expectations.

In terms of the nature of the death, it has been frequently asserted that sudden deaths are more traumatic for survivors and lead to poorer outcomes than deaths that are anticipated. Unfortunately, this has not been well studied, and many different definitions of "suddenness" have been used. While common wisdom holds that time to say goodbye and to express love will facilitate grieving by lessening later feelings of anger and guilt, the moment of death is always a shock no matter how much warning. Moreover, a lengthy terminal illness produces its own stresses and strains that may complicate the grieving process. During a prolonged illness, families are more likely to witness suffering and sometimes dramatic personality changes in the patient that may heighten feelings of anger directed at health professionals and guilt for not having done more (even if no more could have been done) to ease the dying process. If normal social life has been greatly curtailed during a long illness, it can be difficult to re-establish friendships and activities after the death. The bereaved under these circumstances may suffer from substantially diminished social support.

One type of death that clearly leaves survivors

more vulnerable to long-term difficulty is suicide. Family members typically have more psychological distress following a suicide than a death from natural causes. Heightened anger directed at the deceased and guilt for not having been able to prevent the death, as well as true clinical depression, are more likely to occur and to persist. This group of bereaved, especially children whose parent(s) committed suicide, are themselves more vulnerable to suicide (MacMahon and Pugh 1965; Birtchnell 1970; Lloyd 1980).

In addition to the risk factors that are present before bereavement or are related to the nature of the death, some elements of the early bereavement process itself can also affect ultimate outcomes. A consistent finding of nearly all bereavement studies is that among people who already use alcohol, drugs, or cigarettes, consumption of these substances increases. Some people begin using these substances for the first time during a relative's terminal illness or following bereavement. Drinking, smoking, and drug taking are obvious risk factors. Individual symptoms during the early bereavement period that may also predict poor outcome include suicidal preoccupation (particularly after the first month) and morbid (excessive) guilt.

Bereavement researchers have devoted more effort to studying those factors that place people at risk than to the systematic study of factors that may be especially helpful to the bereavement process. There is, however, considerable evidence that social support has a positive effect on general health status and may buffer or modify the impact of adversity on both the mental and physical health of an individual. Conversely, perceived lack of social support is one of the most common risk factors cited in the bereavement literature. The perception

by the recently bereaved that there is no one to talk to or lean on appears to be a reliable predictor of poor outcome (Parkes and Weiss 1983). It is not clear whether the mere presence of social support leads to good outcomes, or whether people who were emotionally healthy to begin with are able to elicit the support they need following bereavement.

Indications of a Need For Professional Intervention

Although bereavement is stressful for virtually everyone, most people are able to move through the process without needing specialized professional help. Some people, however, whose past history makes them especially vulnerable or whose symptoms and behavior following bereavement are too intense should be monitored closely and may need to be helped by a mental health professional. These include adults with a history of depression or alcoholism, adults and children who are bereaved by suicide, and those who have sustained multiple losses within a short time.

Persistent suicidal thoughts and fantasies, a sense of being stuck in one's grief or of being unable to grieve are symptoms that deserve attention. For children, repeated aggressive or hostile behavior, prolonged drop in school performance, persistent sleep disturbance, marked social withdrawal, and inability to talk about the deceased are signs that all is not proceeding normally.

BEREAVEMENT AND CHILDREN

An estimated 5 percent of children in the United States lose one or both parents by the time they are 15 years old. The many children who lose a sibling, friend, or grandparent must also confront the reality of death, and the painful and often frightening emotions associated with bereavement. Bereaved children may be particularly vulnerable to physical and psychological sequelae in both the immediate mourning period and over the longer term. Specific reactions are likely to be influenced by the child's level of cognitive and emotional development when the death occurred.

To avoid misunderstanding bereaved children's behavior, it should be remembered that, although they share some similarities with adults, children's reactions to loss often do not look like adults' reactions. Many differences in behavior, as well as the special vulnerability of children, are due to immaturity and lack of well-developed coping mechanisms. For example, a child who plays games of death or funerals, one who tells strangers on the street "my sister died," or one who resumes play as if nothing distressing has happened, is not behaving inappropriately. Rather, the child is trying to master the loss, test others' reactions to the event, or protect himself from emotions so strong that they can be endured only for brief periods. Feelings that are expressed through misbehavior or angry outbursts may not appear to be, but often are, grief related. Furthermore, children are likely to exhibit

these behaviors for many years after the loss occurred.

In the only prospective study of previously normal children who suffered bereavement, Kaffman and Elizur (1983) followed Israeli children who lost their fathers in 1973. Behavioral problems in these children peaked in the second year, and 40 percent of the children still showed maladaptive behavior in the third year after the father's death. Evaluations at 6, 18, and 42 months after the death showed nearly 70 percent of the children with signs of severe emotional disturbance in at least one followup period such that they were handicapped for at least 2 months in their everyday lives with their families, school, and peer groups.

The data also suggested that children with preexisting emotional difficulties and those from unstable homes were at greater risk of serious pathologic problems than other children. Interestingly, when bereaved kibbutz children were compared with bereaved urban children 18 months after their fathers' deaths, the differences were insignificant (48 percent of kibbutz and 52 percent of urban children exhibited symptoms of persistent pathological grief) suggesting that the social supports and less central role of parents in a kibbutz did not supply much protection (Elizur and Kaffman 1982; Kaffman and Elizur 1983).

Children's ability to work through bereavement and complete their mourning depends in part on their ability to distinguish between death and temporary separations. Before the age of 6 or 7, children do not generally grasp the notion that death is irreversible. After that age, most children understand the finality of death but may not regard it as inevitable, universal, or of immediate relevance to them. By age 11, nearly all children understand that

death is inevitable and represents the end of the life cycle. Only at this point does the child begin to conceptualize the future in terms of potential losses (Koocher 1973). These ages will vary for children who are intellectually precocious or retarded. In addition, children with previous bereavement experience and those who are facing their own deaths are likely to have greater understanding at an earlier age.

There is some theoretical disagreement about the implication of these stages of understanding for the outcome of childhood bereavement. In the past, some experts asserted that because very young children do not understand death and lack the capacity to mourn in a manner analogous to adults, they are unable to complete the process and are likely to have problems for the rest of their lives. A substantial body of research literature now demonstrates that even very young children are able to grieve and use family supports to cope with loss.

The chief difference between bereft children and adults is in the ways they manifest their grief and the need of children to rework and reintegrate understanding of the loss as they develop and are then able to comprehend the event at new levels. Thus, although bereavement may render young children vulnerable, long-term problems are neither as frequent nor as inevitable as was once thought. How a young child fares after sustaining a major loss will depend in large part on the adequacy and availability of supportive adults.

While adolescents are thought to have the maturity to experience sustained pain and complete their mourning, they, too, have a special vulnerability because they are simultaneously experiencing the normal developmental turbulence of adolescence. This already confusing time in life can only be made

more disturbing if the adolescent must deal with the death of a parent, sibling, or peer through illness, or the shock of a violent death by suicide or accident.

Children's Fears, Fantasies, and Behavior

Immediately following bereavement, children are likely to feel sad, angry, and fearful. Depending on their age, they may have eating, bowel and bladder, or speech disturbances, and also commonly develop sleep disturbances. They may become withdrawn or excessively caregiving.

Certain fears and fantasies are likely to occur after a child loses a parent or sibling. Some children fear that they caused the death, they too might die, the dead parent or sibling will return to seek revenge, or the surviving caretaker will die and abandon them. Children may see themselves as helpless and vulnerable, or as hostile and destructive, and use primitive defense mechanisms such as denial, aggression, and idealization in coping with the loss. Three questions, whether articulated or not, commonly occur to children who have lost a parent: Did I cause this to happen? Will it happen to me? Who will take care of me now?

School behavior and achievement often deteriorate after the death of a parent or sibling. Several studies show that poor academic performance and decreased interest in school activities continue for up to 6 years after bereavement (see, for example, Black 1974; Lifshitz 1976). Among adolescent boys, delinquency has sometimes been linked to bereavement, and some observers report that girls turn to sexualized relationships for comfort and reassurance (Raphael 1983).

Reactions to birthdays, holidays, and anniversaries of the death can be considered a normal part

of the grieving process for many years in children as in adults. But children, in contrast to most adults, tend to overtly work and rework their grief as they gain maturity and the necessary skills to cope with it. Thus, children's reactions are likely to be out of synchrony with those of the adults around them. Initially, they may appear to have gotten over the loss too quickly; but months or years later, after the adults have resolved their grief, children may be seen regrieving in a renewed effort to master the loss.

Children at Risk for Poor Outcomes

Although many retrospective studies have concluded that bereaved children are at increased risk for physical and mental illness for the rest of their lives, a thorough review of the literature does not support the notion that negative outcomes are as frequent or as inevitable as has been suggested. The natural developmental push and circumstances following bereavement may help children to be more resilient. As a group, children do appear to be more vulnerable than adults, but many factors can intervene to reduce the chances of life-long problems (Bowlby 1980). This area needs to be better studied.

Many factors, other than the developmental stage, increase the chances of a child suffering excessively prolonged disturbances after the death of a parent. As with spousal bereavement, if the child's relationship with the deceased parent was one of hostility, ambivalence, or overdependence, the resolution of grief and anxiety is likely to be more difficult.

The relationship between the gender of the deceased parent and that of the child has been studied with contradictory results. While some have found

that special anxieties develop when the same-sex parent dies, epidemiologic evidence indicates that the most problematic losses are the death of the mother for a girl under 11 years old, and the death of the father for adolescent boys.

Mental health professionals should be aware of other factors that increase the risk of psychological morbidity. These include excessive dependence on the child by the surviving parent, changes in environment (moving house, disruption of routines, inconsistent discipline, etc.) after the death, suddenness of death, and homicide or suicide. Remarriage of the surviving parent to someone with whom the child has a bad relationship can also complicate the bereavement process.

In children, as in adults, it is difficult to draw the line between normal and abnormal responses to bereavement, and to distinguish symptoms that indicate the need for intervention by mental health professionals from those that are part of the long, painful, but expected experience of grief. The death of a parent or sibling is such a profound loss that some reactions should be viewed as normal that might be considered pathologic in less traumatic circumstances. Some clinicians recommend time-limited intervention for *all* children who lose a parent, followed by annual "bereavement mental health check-ups." Others caution that this could create a self-fulfilling prophecy and focus instead on identifying danger signals that should trigger a referral.

As with adults, the intensity and duration of grief reactions often distinguish normal from pathologic responses. Persistent anxieties, sleep disturbances, blame and guilt, continued hopes for a reunion, persistent suicidal thoughts and behavior, patterns of overactivity with destructive outbursts,

compulsive caregiving, extreme pseudoindependence, euphoria with depersonalization, and identification symptoms should cause concern. Also indicative of a need for help are being unable to speak of the dead parent, exaggerated clinging to the surviving parent, apparent absence of grief, resistance to forming new attachments, complete absorption in daydreams, prolonged dysfunction at school, and delinquency.

MODELS OF THE BEREAVEMENT PROCESS

A number of models have been developed to provide a framework for intervention approaches and to account for variations in reactions to bereavement and ability to return to an earlier level of psychologic function. These models do not represent rigidly different schools of thought but emphasize different aspects of response and therapeutic techniques. In their work with the bereaved, many clinicians utilize concepts from several different models.

The *classical psychoanalytic model* of bereavement, which rests largely on Freudian theory, asserts that the survivor must relinquish ties to the deceased in order to complete grieving. From psychoanalysis, it has been deduced that identification with the deceased is the conduit through which relinquishment occurs; the nature of the identification is an important determinant of bereavement outcome. Clinicians have found that if the deceased was an object of hate or intense ambivalence, certain kinds of depression may occur.

Some *contemporary psychoanalytic and psychodynamically* oriented practitioners focus not only on internal psychic structures, defense mechanisms, and intrapsychic process, but also on interpersonal dynamics. Clinicians generally agree that how people customarily perceive and react will be carried into bereavement. Those who show flexibility and maturity will deal with bereavement more effec-

tively than others. Those who are psychologically healthy are unlikely to be overwhelmed by their pain or unduly frightened by their feelings. Similarly, people with well-integrated personalities are likely to have social networks that will positively influence the outcome to their bereavement. Indeed, social variables—which are linked with personality variables—may be very important predictors of outcome.

Another possible determinant of difficulties following bereavement is the existence of latent negative self-images (weak, hostile, damaged, or defective) that can be activated by losing a person who provided gratification. When such dormant negative images are awakened, distorted thoughts result, and pathologic grieving can occur (Horowitz et al. 1980).

The quality of the relationship with the deceased is regarded as an important dynamic. Freud maintained that the most "important precondition leading to depression following bereavement was an ambivalent relationship with the deceased prior to the death" (Freud 1917). Hostility—whether overtly expressed or unconsciously repressed—is likely to produce increased feelings of remorse after the death. And just as an ambivalent or conflictual relationship interferes with the grieving process, an excessively dependent relationship can be a precondition of a poor outcome.

Researchers draw an analogy from child development. Children who have failed to complete the separation-individuation process tend to become clingy and insecure because they have not developed a secure attachment that would enable the child to turn to the parent for protection.

Interpersonal and attachment models, emphasize social rather than personal meaning. Attachment

theory draws on principles from animal ethology and views the development of strong affectional bonds as instinctive. Breaking such bonds creates personality disturbance and emotional distress. Interpersonal theorists focus on changing social relationships over time and assist the bereaved to develop new ways of relating to others and to practice the behaviors associated with altered roles and status (Bowlby 1980).

Cognitive and behavioral theories provide a framework for understanding depressive and anxiety disorders that may be useful for understanding bereavement reactions. This model postulates that affect and behavior are based on the way an individual structures the world (Beck et al. 1979). Just as people who experience clinical depression have negative views of themselves and their experience, so bereaved people with premorbid negative tendencies could suffer prolonged grief. These people might interpret death as rejection resulting from their inherent defectiveness. Cognitive theorists further add that if a grieving person avoids thoughts of the deceased because the pain is too great, the suppression will create further distress.

Behaviorists focus on manifest behavior after bereavement and environmental factors that encourage certain types of behavior. Thus, individuals who become "stuck" in their grief are likely to be people who customarily avoid confrontation with difficult problems. After a death, such people would avoid situations likely to trigger grief and thus fail to work through their grief (Ramsay 1979). Loss of social reinforcement (e.g., a widow whose life had consisted of serving her husband) can also result in pathologic grief, according to behaviorists.

According to *crisis theory*, the death of an important other disturbs the survivor's homeostasis or

equilibrium (Caplan 1963). Bereavement is conceptualized as a stressful life event that highlights preexisting personality problems that may have lain dormant or not seriously interfered with the person's ability to function. Because the death creates an acute situation, the bereaved may be in danger of increased disorganization. At the same time, however, because the loss intensifies and exaggerates already existing problematic ways of coping and defending, the death may provide an opportunity to recognize and work on formerly entrenched, unconscious issues. Thus, the potentially traumatic life event is viewed as an opportunity for positive growth and change.

Although the training and theories that guide the work of mental health professionals are varied and may differ from those of nontherapists who work with the bereaved, there is likely to be considerable overlap in practice. Both psychotherapy and the lay mutual support approaches provide support and attempt to facilitate and manage grief reactions and improve family relationships. Both approaches may help the bereaved to develop new coping skills or to modify existing ones.

Differences lie in the depth and scope of intervention. Whereas nontherapists may be proficient at helping those who are experiencing normal grief, they are usually not prepared to cope with extreme distress or those highly disturbed reactions that suggest underlying mental illness.

In addition, nontherapists do not use bereavement as an opportunity for more extensive psychotherapeutic work, whereas dynamically oriented therapists, in particular, may explore basic aspects of the personality in order to modify defenses and work through neurotic conflicts or developmental difficulties. The goals of the treatment depend on

the particular wishes of the therapist and patient.

Although the models described differ in emphases and in attribution of causes of responses to grief, most clinicians recognize phases of grieving and the importance of the person's background when assessing the normalcy of response to a bereavement.

Social Support and Sociocultural Influences

People who perceive themselves as having a good social support system are more likely to do well following bereavement than people who feel isolated, with the concommitant feelings of low self-esteem, being unloved, and lacking in personal relationships that might help them through a crisis.

While social support (which can include any number of elements such as shared religious and social rituals, social networks, and the availability of people who permit or elicit emotional release and share values and beliefs) has different meanings for different individuals, the sociocultural climate should also be considered. The meaning of death, ways of expressing grief, coping styles, and expectations of social support vary among cultural groups. And cultural effects are in turn altered by economic and other influences.

Mourning practices in Western countries, especially the United States, have changed in ways that may affect the bereavement process. Also, institutions are taking on new roles. Death is more likely to occur in a hospital than at home, creating new responsibilities for health care providers who interact with the patient, friends, and family before and during the death. Cultural norms appear to expect the period of acute grief to be brief and private. Because so many people today live in large,

heterogeneous communities, the norms and conventions that surround bereavement are not always clear to mourners, leaving them unsure about how long and how much to grieve. The lack of social prescriptions may contribute to serious adjustment and recovery problems.

Cautions About Medications

Although medications are frequently prescribed to reduce anxiety and insomnia and sometimes for depression-like symptoms, there is considerable controversy among physicians about the appropriateness of medication for grief reactions. No controlled studies have been conducted to test the efficacy of these drugs in bereaved populations.

Probably no other class of drugs is used more for grief reactions than hypnotics, since the bereaved typically complain of insomnia. Although sleeping pills may provide some symptomatic relief, they should be used cautiously, if at all, for short-term assistance and under close supervision in order to avoid habitual use and unwanted daytime side effects. In addition, since increased alcohol consumption is a common bereavement reaction, patients should be explicitly counseled about the dangers of combining alcohol and sleeping pills.

During the early weeks of grief when subjective distress is likely to be the greatest, some physicians prescribe benzodiazepines to relieve symptoms of anxiety, fear, tension, "stress", or psychic pain. In recent years, some clinicians have begun prescribing antidepressants to relieve symptoms such as sadness, hopelessness, and other complaints that are common in the early phases of grief. The efficacy of antidepressants for grief reactions has not been studied, and such use would be a new indication not

currently approved by the Food and Drug Administration.

Although antianxiety drugs are known to reduce acute stress and situational neurotic reactions, and antidepressants are of value for episodes of depression, their use during the early phases of the bereavement process and for normal grief reactions is controversial. Many physicians believe that it is inappropriate (and perhaps even ultimately harmful) to interfere with normal grieving. They argue that using drugs to reduce distress will inhibit the adaptive value of grief work, and that failing to grieve or suppressing grief predisposes individuals to later mental disorder or medical disease (Morgan 1980). Others believe that such drugs may help to relieve discomfort, promote better coping, and protect the individual from overwhelming reactions. However, even advocates of psychopharmacy caution against the over-use of drugs, especially over time. "The final resolution of loss is better accomplished by psychological help than by the use of drugs. Although drugs may be helpful in treating . . . the bereaved, their use is adjunctive, symptomatic, and limited in time" (Hollister 1972).

Feelings of anxiety and depression in the early aftermath of a major loss are normal. As long as these symptoms remain within the normal bounds of intensity and duration, they probably should not be treated with medication. A thorough clinical evaluation should be conducted before initiating drug therapy. Furthermore, great caution should be exercised when prescribing drugs for bereavement reactions. Most of these drugs can be habit forming and none mix well with alcohol. Particularly among the elderly, many of these drugs (especially benzodiazepines) can impair coordination and general functioning. Suicidal thoughts in the early weeks of

bereavement are common. For all these reasons, if used at all, medications should be prescribed in the smallest possible dosages and quantities, and patients should be well informed of the risks and closely monitored.

SUPPORTIVE INTERVENTIONS

Data suggest that most bereaved people are likely to benefit from some sort of help, which can range from friendly support and information to intensive therapeutic assistance. Help can come from numerous sources—relatives, friends, clergy and lay caregivers, formal and informal support groups, general health professionals, and mental health professionals.

The type of help given depends on the relationship of the helper to the bereaved, the helper's training, the needs of the bereaved, and the setting in which help is given. As emphasized throughout this booklet, a supportive social network can be of great assistance. Well-informed teachers and health care professionals who have cared for a terminally ill patient may be particularly well situated to assist the family by offering emotional support, providing badly needed information, and monitoring the bereavement process as it unfolds over time. More formal, structured interventions may be needed or desired by some bereaved people.

COMMUNITY RESOURCES

In recent years, the number and variety of resources available to assist the bereaved have proliferated. Although they vary widely in their approaches, audiences, and personnel, they all share a common goal—to help bereaved people cope with a painful life event. This section describes the various kinds of bereavement programs generally available across the country. A list of some national organizations that can provide information about local resources is included in the appendix.

Bereavement programs are difficult to categorize neatly because many combine several different elements. Some distinguishing features that may be especially important to consider in selecting a program include the training of the personnel who provide the assistance, particular characteristics of the clientele for whom the program is designed, and the time of the intervention in the bereavement process.

Mental health professionals should be aware of lay mutual support programs because these may be an appropriate adjunct to psychotherapy and may well be an important source of referrals of potential patients. Knowledge of their goals and approaches may be important for understanding why a bereaved person felt or was thought to be in need of professional assistance.

Lay Versus Professional

Many programs are run by lay people who have themselves been bereaved. The theory behind the

programs is that people who have been through the experience are particularly well situated to help those who are currently trying to cope with it because they understand firsthand the feelings and practical problems the newly bereaved face. These programs (variously termed "mutual support," "lay support," or "self-help" groups) typically offer a lot of information about the bereavement process, emotional support, and practical assistance with such things as funeral arrangements, financial questions, and adjustment to new social roles. Lay volunteers often are required to participate in some formal training before they are permitted to help others. Such help may be offered directly in one-to-one encounters, in group meetings, or indirectly through literature prepared by the group.

Many lay groups employ professional advisors to assist in developing materials, training volunteers, and planning program strategies. Sometimes these groups operate under the broad health care system umbrella in such settings as hospitals, hospices, and health maintenance organizations. They may also be sponsored by churches and synagogues, other community organizations such as the American Association of Retired Persons, or be independent.

In general, the lay mutual support interventions, including hospices, are geared to the vast majority of people who are expected to proceed normally through the bereavement process. For those who appear to be stuck in their grieving or to have abnormal reactions, these groups are often a good source of referral to mental health professionals.

In contrast, mental health professionals are specifically trained and oriented to deal with issues of loss as these might affect functioning and levels of distress over time. Psychotherapeutic interventions for the bereaved may be brief and time-

limited—ranging from about 6 sessions (often called crisis intervention) to 20 or 30 sessions—or it may be long term and open ended. Therapy may be offered to individuals, families, or groups of similarly bereaved people.

Because many different theories guide psychotherapy with the bereaved, the type of help offered will depend both on the patient's needs and goals and the practitioner's particular orientation. Despite differences in method and approach, mental health professionals share common goals in working with the bereaved: nonjudgmental support, compassion, and a desire to help the bereaved person or family resume adequate functioning and a sense of well-being.

Characteristics of Bereaved Clientele

The choice of program or professional depends in large part on the characteristics of the bereaved. In recent years, there has been a tremendous growth in support groups to assist people anticipating death from particular diseases and those who are bereaved by particular circumstances. For virtually every major life-threatening illness, there are support groups that offer help to the patient and/or his family. These groups tend to focus primarily on prebereavement support and offer little assistance afterward. Numerous programs are designed to assist people who have experienced various kinds of sudden and especially violent deaths, such as SIDS, suicide, homicide, and automobile accidents.

Many bereavement groups offer support to widows; relatively few are designed specifically for widowers, children who have lost a sibling or parent, or adults whose elderly parents have died.

Timing of the Intervention

Many programs are geared to those who are already bereaved. Some offer immediate assistance and others work with the bereaved starting a month or more after the death. The original widow-to-widow model included immediate one-to-one support followed by group support after a couple of months. Hospice bereavement services offer assistance to the patient and family beginning when the patient is admitted to the hospice program and often continuing for as long as 1 year after the death has occurred. Increasingly, mental health professionals are developing short-term structured therapy to help resolve particular grief reactions.

THE IMPACT OF BEREAVEMENT INTERVENTIONS

Despite the proliferation of mutual support groups and psychotherapeutic approaches to assist the bereaved, very little research has been done to evaluate their effects. However, the literature is replete with testimonials from individuals who describe how helpful programs have been. The little formal research that has been done often suffers from methodologic problems including small sample sizes and lack of control groups. But such evaluation research has inherent difficulties because programs and approaches are so varied, the clientele are diverse, and there is little agreement about what outcomes should be assessed and how to measure them.

Little is known about which specific program elements are helpful or harmful. Nonetheless, subjective reports and the clinical judgment of health professionals suggest that, for many people, some assistance is useful in coping with the stress of bereavement. Having information about the nature of the process, nonjudgmental support, and encouragement do appear to be helpful.

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APPENDIX

Health care professionals should be aware of the variety of resources in their community for the bereaved who want or need outside assistance. The following list may be useful in showing the scope of mutual support programs and in determining their availability in particular communities. To find out about resources in your community, the following may be particularly helpful: churches and synagogues, hospital departments of psychiatry and social services, State and local mental health departments, national organizations for particular diseases or kinds of deaths (to find out about local chapters and to get their literature), school personnel, community centers, and funeral directors.

POSTBEREAVEMENT MUTUAL SUPPORT GROUPS

For Widowed Persons

THEOS (They Help Each Other Spiritually)
Office Building, Suite 306
Penns Hill Mall
Pittsburgh, PA 15235

For young and middle-aged widowed persons; each chapter has a chaplain; 100 chapters nationwide.

Widow-to-Widow Programs

Hundreds of local mutual help groups and networks sponsored by churches/synagogues, YM/YWCAs, community mental health centers, family service associations, mental health associations, funeral directors associations, and freestanding community groups.

Widowed Person Service Directory lists about 400 groups nationwide. New Jersey Self-Help Clearinghouse lists 42 in State of New Jersey alone.

Widowed Persons Service
American Association of Retired Persons
1909 K Street, N.W.
Washington, D.C. 20049

Peer support and visitation to widowed persons; 135 groups nationwide; AARP-WPS provides consultation and training for leaders of new local groups.

For Survivors of Suicide

Seasons: Suicide Bereavement, Inc.
4777 Maniloa Drive
Salt Lake City, UT 84117

For families and individuals (including therapists, police, and work colleagues) who have lost a significant other by suicide; co-facilitators involved in support group discussions—a survivor and a professional; national organization.

Survivors of Suicide (S.O.S.)
c/o Fr. Arnaldo Pagrazzi, Chaplain
St. Joseph's Hospital
5000 W. Chambers Street
Milwaukee, WI 53210

For families and friends of suicide victims.

For Parents

The Compassionate Friends
P.O. Box 1347
Oak Brook, IL 60521

For bereaved parents; 325 groups nationwide.

Families of Homicide Victims
2 Lafayette Street
New York, NY 10007

For parents of homicide victims.

Mothers Against Drunk Drivers (MADD)
5330 Primrose, Suite 146
Fair Oaks, CA 45628

Open to all citizens; many are survivors of drunk driver caused crashes; many are relatives and friends of victims; national organization.

National Foundation for Sudden Infant Death (SIDS)
1501 Broadway
New York, NY 10036

For parents who have lost a child to crib death.

National Sudden Infant Death Syndrome Foundation
8240 Professional Place
2 Metro Plaza, Suite 205
Landover, MD 20785

For parents who have lost a child to crib death; national organization.

Parents of Murdered Children
1739 Bella Vista
Cincinnati, OH 45237

For parents of murdered children; recently established a new category of group—Survivors, for other relatives such as sibling, grandparent, and adult child of a murdered parent. 40 chapters nationwide plus contact persons.

VOLUNTARY ASSOCIATIONS (WITH SUPPORT GROUPS) AND MUTUAL HELP GROUPS FOR PATIENTS AND FAMILIES WITH LIFE-THREATENING ILLNESSES

Alzheimer's Disease and Related
Disorders Association
2501 West 84th
Bloomington, MN 55431

For caregivers of Alzheimer's patients.

American Cancer Association
777 Third Avenue
New York, NY 10017

- Man-to-Man: Peer visitation programs by partners of women who have mastectomies
- Reach to Recovery: Peer counseling by women who have undergone mastectomy
- Lost Chord, Anamilio, and New Voice Clubs: 260 clubs nationwide are members of International Association of Laryngectomies
- I Can Cope: A support group for cancer patients and their families

American Lupus Society
23751 Madison Street
Torrance, CA 90505

For patients and families; 100 chapters nationwide.

American Parkinson's Disease Association
116 John Street
New York, NY 10038

For Parkinson patients, their families and friends.

Amyotrophic Lateral Sclerosis Society of America
15300 Ventura Boulevard, Suite 315
P.O. Box 5951
Sherman Oaks, CA 91403

For patients and their families.

Association of Heart Patients
P.O. Box 54305
Atlanta, GA 30308

Candlelighters Association
2025 I Street, N.W.
Washington, DC 20006

For parents of children with cancer; 155 chapters nationwide. Newsletters of other publications for parents and adolescents as well as support groups.

Center for Attitudinal Healing
10 Main Street
Tiburon, CA 94920

Mutual help pen pal/phone pal program for children, parents, or other adults with life-threatening illness.

CHUMS
(Cancer Hopefuls United for Mutual Support)
3310 Rochambeau Avenue
New York, NY 10467

For cancer patients/survivors and their families and friends.

Committee to Combat Huntington's Disease, Inc.
250 W. 57th Street
New York, NY 10107

For patients and affected families; 29 chapters nationwide plus branches and area representatives in 44 states.

Coronary Clubs, Inc.
3659 Green Road
Cleveland, OH 44122

C.U.R.E. Childhood Cancer Association
315 Marion Street
Rochester, NY 14610

For children and families.

Cystic Fibrosis Foundation
6000 Executive Boulevard, Suite 309
Rockville, MD 20852

For parents of children with cystic fibrosis; national organization.

Gillain–Barre Support Groups
1305 Wyngate Road
Wynnewood, PA 19096

For victims of GB Syndrome.

The Lupus Foundation
11673 Holly Springs Drive
St. Louis, MO 63141

For patients and families; 70 chapters nationwide.

Make Today Count
P.O. Box 303
Burlington, IA 52601

For persons facing a life–threatening illness and their relatives and friends; 300 chapters nationwide.

Myasthenia Gravis Foundation
15 East 26th Street
New York, NY 10010

For myasthenics, relatives, and friends; 51 chapters nationwide.

National AIDS Network
729 8th Street, S.E.
Suite 300
Washington, DC 20003

Information clearinghouse for AIDS patients, friends, and families regarding resources in local communities across the country.

National Association of Patients on Hemodialysis and Transplantation
156 Williams Street
New York, NY 10038

For patients, their families and friends; 33 chapters nationwide.

National Head Injury Foundation
18A Vernon Street
Framingham, MA 01701

For families of head injured; 28 chapters nationwide.

National Hospice Organization
1901 North Fort Myer Drive
Arlington, VA 22209

For terminally ill patients and their families; more than 1,000 hospice programs nationwide.

National Multiple Sclerosis Society
205 East 42nd Street
New York, NY 10017

For patients and their families; 124 chapters nationwide.

National Tay-Sachs Parent Network
122 E. 42nd Street
New York, NY 10017

For parents of children with Tay-Sachs.

Parents of Prematures
13613 NE 26th Place
Bellevue, WA 98005

For parents who experience birth and hospitalization of premature or critically ill babies.

Phoenix Society
11 Rusthill Road
Levittown, PA 19056

Recovered burn victims work with severely burned people and their families; national organization.

SHARE (Self-Help Action and Rap Experience)
34 Gramercy Park
New York, NY 10003

For women who have had a mastectomy.

SKIP (Sick Kids Need Involved People)
216 Newport Drive
Severna Park, MD 21146

Helping families of children with various levels of medical instability care for their child at home; new organization.

Spina Bifida Association of America
343 South Dearborn, Suite 319
Chicago, IL 60604

100 chapters nationwide.

Stroke Clubs
7320 Greenville Avenue
Dallas, TX 75321

For those who have had strokes and their families; 312 clubs nationwide.

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